Adverse Transfusion Reaction

Should one of your patients experience a possible transfusion reaction, we recommend the following protocol to help us best support your team:

1. If this is an urgent matter that requires immediate assistance, please contact our Central Office team at (204) 632-2586.
2. For non-urgent matters, or following an urgent matter discussion with our Central Office team, please complete and submit the Adverse Transfusion Reaction form provided below to admin@canadiananimalbloodbank.ca.
    a. Use the following Subject Line for your email: “URGENT: Adverse Transfusion Reaction”.
    b. Ensure the completed Adverse Transfusion Reaction form is attached.
3. Reserve the following samples for possible submission for further testing by our team:
    a. serum or plasma sample(s) from recipient PRE transfusion reaction
    b. serum or plasma sample(s) from recipient POST transfusion reaction
    c. blood product unit suspected of adverse reaction
4. After your form has been received and reviewed, a member of our team will follow up to discuss the next steps.

Please note: serum samples should be separated from red cells following sample collection. All samples should be refrigerated while awaiting follow-up from our team.

Adverse Transfusion Reaction

Please complete and submit the Adverse Transfusion Reaction form provided below to admin@canadianananimalbloodbank.ca.

Use the following Subject Line for your email: “URGENT: Adverse Transfusion Reaction”.

Hospital Information

Hospital Name:	Address:
City:	Province:
Phone Number:	Email Address:

Preferred method of contact? ☐ Phone ☐ Email
Name of contact person: _____

Patient Information

Name (last, first):	Date of Birth (dd/mm/yyyy):
Species:	Breed:
Sex: ☐ Male ☐ Female	☐ Intact ☐ Spayed/Neutered

Clinical History (Please select all that apply)

Blood Group: ☐ DEA 1+ ☐ DEA1- ☐ Unkown/Typing not performed
Please provide results of additional blood group testing (e.g. Dal, DEA4, etc.):

Previous Transfusion? ☐ Yes ☐ No ☐ Unknown
If yes, please provide the transfusion date(s) and product(s) received:

Was a Major Crossmatch performed prior to the transfusion? ☐ Yes ☐ No
Was a Minor Crossmatch performed prior to the transfusion? ☐ Yes ☐ No

Transfused under anaesthesia? ☐ General ☐ Regional/local ☐ None

Immunocompromised? ☐ Yes ☐ No
If yes, please elaborate:

Patient Diagnosis: _____

Indication for Transfusion: _____

Other Relevant Clinical History: _____

Date & Time of Transfusion Reaction

Date (dd/mm/yyyy)	Transfusion Started (hh:mm)	Adverse Reaction Noted (hh:mm)	Transfusion Stopped (hh:mm)

Was transfusion restarted? ☐ Yes ☐ No

If yes, please provide the date and time the transfusion was restarted:

Clinical Signs and Symptoms

Vitals	Before Transfusion	After Adverse Reaction	Notes
Time (hh:mm)			
Temperature		Enter highest value measured	
Pulse			
Respiration Rate			
Blood Pressure			

☐ Fever
☐ Tremors
☐ Hypertension
☐ Hypotension
☐ Nausea/vomiting
☐ Pruritus
☐ Urticaria
☐ Anaphylaxis

☐ Bradycardia
☐ Tachycardia
☐ Restlessness/anxiety
☐ Vocalisation
☐ Dyspnea
☐ Orthopnea
☐ Pulmonary crackles
☐ Hypoxemia

☐ Shock
☐ Jaundice
☐ Oliguria
☐ Hemoglobinuria
☐ Hemoglobinemia
☐ Pain/discomfort
☐ Other: _____
_____

Laboratory Results

Laboratory Test	Testing Date	Testing Time	Result

Blood Culture Results

Sample Source	Date Specimen Taken	Time Specimen Taken	Result

Blood Product Information

Blood Product	Unit Number	Expiration Date	Total Volume Administered (ml)

Were any product abnormalities noted during the visual inspection prior to product administration? ☐ Yes ☐ No ☐ Not Performed

If yes, please provide further details:

Was the product warmed prior to administration? ☐ Yes ☐ No

If yes, please provide further details:

Does your hospital monitor temperatures of storage devices/facilities? ☐ Yes ☐ No

If yes, what practices do you implement?

Transfusion Supplies and Equipment

Was a filter used to administer the blood product(s)? ☐ Yes ☐ No

Method of Transfusion Administration: ☐ Infusion Pump ☐ Syringe Pump ☐ Gravity

Actions Taken

- ☐ None
- ☐ Transfusion Stopped
- ☐ Transfusion Restarted
- ☐ Antibiotics
- ☐ Antihistamines
- ☐ Recipient Blood Culture
- ☐ Product Culture
- ☐ Antipyretics
- ☐ Diuretics
- ☐ Supplementary O2
- ☐ Steroids
- ☐ Vasopressors
- ☐ Chest X-Ray
- ☐ Other

Current Status/Concerns

Patient Status at Time of Reporting:

Main Concern(s):

Reported By:

_____ _____

Name(print) Designation

_____ _____

Signature Date/Time

Did you speak with a CABB team member? ☐ Yes ☐ No

Name of CABB team member who assisted you: _____

For Internal Use Only

Date received: _____

Staff involved in review: _____

Description of review and analysis of issue: _____

_____

Outcome: _____

_____

Issue:

- ☐ Resolved
- ☐ Pending further review
- ☐ Insufficient information provided
- ☐ Other: _____

_____ _____

Signature of staff that completed the review Signed by ED and/or Board President

Copy sent to the Laboratory Director to include information in the Adverse Reaction report and monitoring. Reports to be reviewed quarterly by Quality Control & Education Advisory Committees.